BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
Scott Jeffrey Tushla, M.D.	)	Case No. 800-2014-010304
Physician's and Surgeon's Certificate No. G 86841	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on December 8, 2017.

IT IS SO ORDERED: November 9, 2017.

MEDICAL BOARD OF CALIFORNIA

Kristina Lawson, J.D., Chair
Panel B

XAVIER BECERRA
Attorney General of California
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SCOTT JEFFREY TUSHLA, M.D.** **564 Vista Grande** **Colorado Springs, CO 80906** **Physician's and Surgeon's Certificate No. G 86841** Respondent.	Case No. 800-2014-010304 OAH No. 2017051194 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Tan N. Tran, Deputy Attorney General.

2. Respondent SCOTT JEFFREY TUSHLA, M.D. (Respondent) is represented in this proceeding by attorney Corey E. Krueger, whose address is: Law & Brandmeyer, LLP, 2 North Lake Avenue, Suite 820, Pasadena, CA 91101.

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3. On or about April 9, 2003, the Board issued Physician's and Surgeon's Certificate No. G 86841 to SCOTT JEFFREY TUSHLA, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2014-010304, and will expire on April 30, 2019, unless renewed.

JURISDICTION

4. Accusation No. 800-2014-010304 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on March 6, 2017. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2014-010304 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2014-010304. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent does not contest that, at an administrative hearing, complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2014-010304. and that he has thereby subjected his license to disciplinary action.

10. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 800-2014-010304. shall be deemed true, correct and fully admitted by respondent for purposes of that proceeding or any other licensing proceeding involving respondent in the State of California.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

RESERVATION

12. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

13. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

14. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 86841 issued to Respondent SCOTT JEFFREY TUSHLA, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

2. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65

hours of CME of which 40 hours were in satisfaction of this condition.

3. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the

Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of

medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.]

6. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

STANDARD CONDITIONS

7. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

8. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses, except while continuing to work for DaVita Health Care or any successor that continues Respondent in his duties at Penrose Hospital, St. Francis Medical Center, Memorial Hospital Central, and Memorial Hospital North.

9. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

10. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and

residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's place of residence. If Respondent engages in the practice of medicine in a patient's place of residence, the medical records for this patient must be maintained in respondent's office.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice ,Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

12. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation. While respondent is out of state, due consideration will be given to Respondent's geographic location and on-call responsibilities when arranging interviews pursuant to this Section.

13. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct

patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing..

14. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

15. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and

carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

16. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

17. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Corey E. Krueger. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 8-14-17

SCOTT JEFFREY TUSHLA, M.D.
Respondent

I have read and fully discussed with Respondent SCOTT JEFFREY TUSHLA, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 8/22/2017

COREY E. KRUEGER
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 8/23/17

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

TAN N. TRAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2014-010304

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Scott Jeffrey Tushla, M.D.** **564 Vista Grande Drive** **Colorado Springs, CO 80906** **Physician's and Surgeon's Certificate No. G 86841,** Respondent.	Case No. 800-2014-010304 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about April 9, 2003, the Medical Board issued Physician's and Surgeon's Certificate Number G 86841 to Scott Jeffrey Tushla, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2017, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program."

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the board deems proper.

6. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview scheduled by Board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

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7. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

8. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

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9. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence - Patient M.T.)

10. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code for the commission of acts or omissions involving gross negligence in the care and treatment of patient M.T.[1] The circumstances are as follows:

Patient M.T.

11. Respondent treated patient M.T. (or "patient"), a forty-nine year-old female, from about January 2014 through March 2015.[2] The patient had diagnoses of obesity, anxiety,

[1] The patients are identified by initial to protect their privacy.

[2] These are approximate dates, per the records available for review. The patient may have treated with respondent before and after these dates.

depression, insomnia, supraventricular tachycardia, and multiple family and life stresses. There was also a question whether the patient had a bipolar disorder. Records indicate that from January 6, 2014 to March 17, 2015, respondent prescribed multiple prescriptions to the patient including Clonazepam, Alprazolam, Diazepam, Temazepam, Zolpidem Tartrate, and Phentermine.[3] Many of the prescriptions written by respondent contained multiple refills.

12. Review of the medical records show that a medical history was taken and physical exams were completed. However, respondent did not document whether he asked the patient about a detailed substance abuse history. Records reviewed also did not include notes from initial exams.

13. Although the medical records stated objectives that were consistent with respondent's prescribing of benzodiazepines to this patient, there were instances in which respondent did not comply with the standard of care for prescribing controlled substances to this patient. For example, on the March 26, 2014, appointment, the plan states, "wrote limited Xanax." Yet a review of the CURES[4] report shows that the patient filled prescriptions for Lorazepam 0.5 mg #60 from respondent on March 26, 2014, and on April 2, 2014 the patient filled a prescription for Alprazolam 1 mg #90. This was in addition to the patient's already having filled a prescription from respondent for Alprazolam 1 mg #90 on March 24, 2014.

14. Another example is the June 2, 2014 clinic visit where respondent wrote, "wean off benzos." Yet the patient received benzodiazepine prescriptions written by respondent for 2 mg Alprazolam on June 9, 2014, June 25, 2014, and July 14, 2014, all for 30 tablets on each prescription. This was in addition to respondent's prescription for 1 mg Clonazepam on June 3, 2014, and July 7, 2014, for 60 tablets on each prescription and 5 mg Diazepam on June 25, 2014, and July 14, 2014, for 30 tablets on each prescription.

15. Moreover, the multiple benzodiazepine prescriptions that were written in contrast to what was documented in the record shows a clear lack of periodic review by respondent regarding

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[3] All dangerous drugs with potentially addictive traits and side effects, if used improperly and/or overused.

[4] A database which contains information on a person's prescribing history, including the type of drug prescribed, the prescribing doctor, and the patient name.

his treatment of this patient. Per the records available for review, it appeared that the patient had a four-month gap in being seen by respondent between June 2, 2014 and October 2, 2014. Yet during this period, the patient received fourteen prescriptions from respondent for four different benzodiazepines. In addition, the CURES report shows that the patient was also receiving prescriptions from another doctor for Clonazepam at the same time.

16. The medical records are not clear but, at some point, the patient was seen by a psychiatrist. When or if the psychiatry consult was sent and whether the patient completed the referral was not documented in the records.[5] The medical documentation was done through an electronic medical record (EMR) using a standard SOAP (Subjective, Objective, Assessment, and Plan) format. Entries were brief statements with frequent medical shorthand. The history provided was brief, often repeated and did not go into detail.

17. The assessment and plan section in the EMR was very difficult to follow and understand. This was especially true for medications, where doses and quantities were often omitted. In addition, when medications were written out, it was followed by the phrase "...prescription: not prescribed this visit." Another confusing aspect in the record was seen in the assessment section which led with the phrase, "No assessment recorded," which was then followed by a diagnosis. These acts and omissions in the treatment of this patient constituted an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts - 4 Patients)

18. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts in his care of patients M.T. above, D.T., E.B., and P.C. The circumstances are as follows:

19. The facts and circumstances in paragraphs 11 through 17, above, are incorporated by reference as if set forth in full herein.

[5] Respondent should have referred this patient to a psychiatrist/psychologist sooner during his treatment of the patient due to her long-standing anxiety, multiple family issues, questionable diagnosis of bipolar disorder, and her need for long-term benzodiazepines.

20. Respondent also committed repeated negligent acts in his care of patient D.T. The circumstances are as follows:

Patient D.T.

21. Respondent treated patient D.T. (or "patient"), a forty-seven year-old male, from about April 2013 through April 2015.[6] The patient had diagnoses of depression, anxiety, and chronic low back pain. The patient frequently complained of acute low back episodes, anxiety, and family difficulties. CURES reports for this patient show numerous prescriptions for controlled substances such as Hydrocodone, Clonazepam, Alprazolam, Lorazepam, and Hydromorphine.

22. Review of the medical records show that a medical history was taken and physical exams were completed. Respondent did not document whether he asked the patient about a detailed substance abuse history. The records reviewed did not include notes from initial exams. The patient reported significant anxiety and low back pain but clear indications were not documented as to why multiple benzodiazepines (e.g. Diazepam, Alprazolam, and Clonazepam) were required at the same time to treat this patient.[7]

23. Also, the treatment objectives and plan were difficult to follow for this patient. Confirmation of improved pain and psychological functioning was based solely on the patient's report. No psychological screening tests were reported nor was consideration of referral to psychology or psychiatry documented. It was documented on May 13, 2013 that the patient "...did want counseling and did not want meds." Yet, the very next line in the clinic note contains a prescription for Clonazepam.

24. No documentation of confirmatory urine screening was seen in the record. No documentation was reported that CURES reports were requested or reviewed. The records respondent kept for this patient made it difficult to follow what controlled medications the patient was taking between visits and what the patient was prescribed at each visit. Also, it was not

[6] These are approximate dates, per the records available for review. The patient may have treated with respondent before and after these dates.

[7] Even respondent questioned the use of these medications when he wrote on February 6, 2015, "I would prefer him not to use this" after an Alprazolam prescription.

clearly documented why persistent complaints of stress and anxiety, lack of energy, and the need for multiple benzodiazepines did not result in a referral to a mental health provider.

25. The medical documentation was done through an electronic medical record using standard SOAP (Subjective, Objective, Assessment, and Plan) format. Entries were brief statements with frequent medical shorthand. The history provided was brief, often copied from prior visits and did not go into detail. The assessment and plan section was very difficult to follow and understand. This was especially true for medications, where doses and quantities were often omitted. In addition, when medications were written out, it was followed by the phrase, "...prescription: not prescribed this visit." Another confusing aspect in the record was seen in the assessment section which often led with the phrase, "No assessment recorded," which was then followed by a diagnosis.

26. The prescribing of controlled substances, the failure to perform and document an adequate history and physical exam prior to prescribing controlled substances, the failure to document an adequate treatment plan and objectives, the failure to perform an adequate periodic review of the course of treatment for the patient, the failure to obtain additional evaluations and consultations, and the failure to maintain adequate, accurate, and complete records, as outlined above, departed from the standard of care.

Patient E.B.

27. Respondent was the primary care provider for patient E.B. (or "patient"), a sixty-nine year-old female whose diagnoses included chronic low back pain, diabetes, hypothyroidism, hypertension, prior lumbar and gastric bypass surgery. Respondent prescribed Hydrocodone 10/325 for the patient's pain, on a monthly basis.

28. The medical documentation was done through an electronic medical record using standard SOAP (Subjective, Objective, Assessment, and Plan) format. Entries were brief statements with frequent medical shorthand. The history provided was brief, often copied from prior visits and did not go into detail. The assessment and plan section was very difficult to follow and understand. This was especially true for medications, where doses and quantities were often omitted. In addition, when medications were written out, it was followed by the phrase,

"...prescription: not prescribed this visit." Another confusing aspect in the record was seen in the assessment section which often led with the phrase, "No assessment recorded," which was then followed by a diagnosis.

29. Respondent's maintenance of records regarding his treatment of this patient constituted a simple departure from the standard of care.

Patient P.C.

30. Respondent was the primary care provider for patient P.C. (or "patient"), a seventy-seven year-old male whose diagnoses included peripheral neuropathy, malignant melanoma, intercostal neuralgia, hypertension, unexplained weight loss, abdominal pain, lumbar radiculopathy, restless leg syndrome, and osteoarthritis. The patient went once to Community Memorial Hospital due to suicidal ideation in January 2015, which was related in part to his difficulty finding adequate pain control. The patient-physician relationship between the patient and respondent was also difficult, relating to the patient's non-compliance with medical recommendations.

31. Per the medical records, respondent prescribed to this patient two prescriptions of Hydrocodone and two prescriptions of Hydromorphone over a six-week period in October and November of 2014.

32. Similar to the aforementioned patients, the medical documentation for patient P.C. was done through an electronic medical record using standard SOAP (Subjective, Objective, Assessment, and Plan) format. Entries were brief statements with frequent medical shorthand. The history provided was brief, often copied from prior visits and did not go into detail. The assessment and plan section was very difficult to follow and understand. This was especially true for medications, where doses and quantities were often omitted. In addition, when medications were written out, it was followed by the phrase, "...prescription: not prescribed this visit." Another confusing aspect in the record was seen in the assessment section which often led with the phrase, "No assessment recorded," which was then followed by a diagnosis.

33. Respondent's maintenance of records regarding his treatment of this patient constituted a simple departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Prescribing Without Exam/Indication- 2 patients)

34. By reason of the facts and allegations set forth in the First and Second Causes for Discipline above, Respondent is subject to disciplinary action under section 2242 of the Code, in that Respondent prescribed dangerous drugs to patients M.T. and D.T., without an appropriate prior examination or medical indication therefor.

FOURTH CAUSE FOR DISCIPLINE

(Excessive Prescribing- 2 patients)

35. By reason of the facts and allegations set forth in the First and Second Causes for Discipline above, Respondent is subject to disciplinary action under section 725 of the Code, in that Respondent excessively prescribed dangerous drugs to patients M.T. and D.T.

FIFTH CAUSE FOR DISCIPLINE

(Inadequate Records- 4 patients)

36. By reason of the facts and allegations set forth in the First and Second Causes for Discipline above, Respondent is subject to disciplinary action under section 2266 of the Code, in that Respondent failed to maintain adequate and accurate records of his care and treatment of patients M.T., D.T., E.B., and P.C.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 86841, issued to Scott Jeffrey Tushla, M.D.;

2. Revoking, suspending or denying approval of Scott Jeffrey Tushla, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Scott Jeffrey Tushla, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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4. Taking such other and further action as deemed necessary and proper.

DATED: March 6, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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